

Facility Name & ID Number Winston Manor Cnv & Nursing

0035782 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 180

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	180	Intermediate (ICF)	180	65,700	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	180	TOTALS	180	65,700	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	55,336	366	239	55,941	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	55,336	366	239	55,941	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.15%

D. How many bed-hold days during this year were paid by the Department?

186 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

N/A

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 01/01/1990

J. Was the facility purchased or leased after January 1, 1978?

YES Date 1989 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/2009 Fiscal Year: 12/31/2009

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Winston Manor Cnv & Nursing # 0035782 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	232,893	20,997	9,795	263,685		263,685	28,000	291,685		1
2	Food Purchase		195,496		195,496	(18,828)	176,668	(38)	176,630		2
3	Housekeeping	192,366	30,912		223,278		223,278		223,278		3
4	Laundry		5,012		5,012		5,012		5,012		4
5	Heat and Other Utilities			101,449	101,449		101,449	2,131	103,580		5
6	Maintenance	65,918	27,063	2,019	95,000		95,000	30,662	125,662		6
7	Other (specify):* Attached Schedule			13,917	13,917		13,917		13,917		7
8	TOTAL General Services	491,177	279,480	127,180	897,837	(18,828)	879,009	60,755	939,764		8
	B. Health Care and Programs										
9	Medical Director			3,250	3,250		3,250		3,250		9
10	Nursing and Medical Records	1,118,532	29,521	170,264	1,318,317		1,318,317		1,318,317		10
10a	Therapy	32,390		195	32,585		32,585		32,585		10a
11	Activities	87,402	2,493		89,895		89,895		89,895		11
12	Social Services	154,466		8,115	162,581		162,581		162,581		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* MDS Coordinator	54,264			54,264		54,264		54,264		15
16	TOTAL Health Care and Programs	1,447,054	32,014	181,824	1,660,892		1,660,892		1,660,892		16
	C. General Administration										
17	Administrative	28,300		382,470	410,770		410,770	(172,991)	237,779		17
18	Directors Fees										18
19	Professional Services			51,583	51,583		51,583	(4,002)	47,581		19
20	Dues, Fees, Subscriptions & Promotions			29,026	29,026		29,026	(11,230)	17,796		20
21	Clerical & General Office Expenses	41,872		59,871	101,743		101,743	84,164	185,907		21
22	Employee Benefits & Payroll Taxes			352,163	352,163	18,828	370,991	28,952	399,943		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,480	1,480		1,480		1,480		24
25	Other Admin. Staff Transportation			5,474	5,474		5,474	22	5,496		25
26	Insurance-Prop.Liab.Malpractice			87,396	87,396		87,396	1,218	88,614		26
27	Other (specify):* Bad Debt Expense			418	418		418	(418)			27
28	TOTAL General Administration	70,172		969,881	1,040,053	18,828	1,058,881	(74,285)	984,596		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,008,403	311,494	1,278,885	3,598,782		3,598,782	(13,530)	3,585,252		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number

Winston Manor Cnv & Nursing

#0035782

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			20,865	20,865		20,865	52,709	73,574			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			468	468		468	(468)				32
33	Real Estate Taxes							215,436	215,436			33
34	Rent-Facility & Grounds			592,436	592,436		592,436	(592,436)				34
35	Rent-Equipment & Vehicles			24,761	24,761		24,761	429	25,190			35
36	Other (specify):*											36
37	TOTAL Ownership			638,530	638,530		638,530	(324,330)	314,200			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		350		350		350		350			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			98,550	98,550		98,550		98,550			42
43	Other (specify):*							37,274	37,274			43
44	TOTAL Special Cost Centers		350	98,550	98,900		98,900	37,274	136,174			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,008,403	311,844	2,015,965	4,336,212		4,336,212	(300,586)	4,035,626			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	800	30		9
10	Interest and Other Investment Income	(468)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(38)	2		13
14	Non-Care Related Interest	(51)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(890)	21		18
19	Entertainment				19
20	Contributions	(36,260)	21		20
21	Owner or Key-Man Insurance	(478)	22		21
22	Special Legal Fees & Legal Retainers	(4,550)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(418)	27		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(6,098)	20		28
29	Other-Attach Schedule	(5,878)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (54,329)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(246,257)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (246,257)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (300,586)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	52

Winston Manor Cnv & Nursing

ID# 0035782

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Trust Fee	\$ (190)	21	1
2	Non-Deductible Dues	(5,623)	20	2
3	Franchise Tax - Management Company	(23)	21	3
4	Sales Tax - Management Company	(303)	2	4
5	Employee Background Checks Paid by Mng Comp	261	20	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(5,878)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Winston Manor Cnv & Nursing# 0035782

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	28,000	0	0	0	0	0	0	0	0	28,000	1
2	Food Purchase	(341)	303	0	0	0	0	0	0	0	0	0	(38)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	2,131	0	0	0	0	0	0	0	0	0	2,131	5
6	Maintenance	0	1,641	29,021	0	0	0	0	0	0	0	0	30,662	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(341)	4,075	57,021	0	60,755	8							
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	(172,991)	0	0	0	0	0	0	0	0	(172,991)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(4,550)	0	548	0	0	0	0	0	0	0	0	(4,002)	19
20	Fees, Subscriptions & Promotions	(11,460)	109	121	0	0	0	0	0	0	0	0	(11,230)	20
21	Clerical & General Office Expenses	(37,363)	1,293	120,234	0	0	0	0	0	0	0	0	84,164	21
22	Employee Benefits & Payroll Taxes	(478)	29,430	0	0	0	0	0	0	0	0	0	28,952	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	22	0	0	0	0	0	0	0	0	22	25
26	Insurance-Prop.Liab.Malpractice	0	1,218	0	0	0	0	0	0	0	0	0	1,218	26
27	Other (specify):*	(418)	0	0	0	0	0	0	0	0	0	0	(418)	27
28	TOTAL General Administration	(54,269)	32,050	(52,066)	0	(74,285)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(54,610)	36,125	4,955	0	(13,530)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Winston Manor Cnv & Nursing# 0035782

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	800	0	51,909	0	0	0	0	0	0	0	0	52,709	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(519)	51	0	0	0	0	0	0	0	0	0	(468)	32
33	Real Estate Taxes	0	0	215,436	0	0	0	0	0	0	0	0	215,436	33
34	Rent-Facility & Grounds	0	0	(592,436)	0	0	0	0	0	0	0	0	(592,436)	34
35	Rent-Equipment & Vehicles	0	429	0	0	0	0	0	0	0	0	0	429	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	281	480	(325,091)	0	(324,330)	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	37,274	0	0	0	0	0	0	0	0	37,274	43
44	TOTAL Special Cost Centers	0	0	37,274	0	37,274	44							
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(54,329)	36,605	(282,862)	0	(300,586)	45							

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Marvin Mermelstein	75.70	Balmoral Home, Inc.	Chicago	Nivram Mngmt, Inc.	Lincolnwood	Management
Joseph Mermelstein	24.30	Chicago Ridge Nursing Center	Chicago Ridge	Pierce Bldg Partnsp	Lincolnwood	Lessor
		Central Home, Inc.	Chicago			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V	21 Delivery Expense	\$	Nivram Management, Inc.	50.00%	\$ 139	\$	139	1
2	V	21 Office Expenses		Nivram Management, Inc.	50.00%	1,131		1,131	2
3	V	20 Dues & Subscriptions		Nivram Management, Inc.	50.00%	109		109	3
4	V	21 Franchise Tax		Nivram Management, Inc.	50.00%	23		23	4
5	V	32 Interest Expense		Nivram Management, Inc.	50.00%	51		51	5
6	V	22 Payroll Taxes		Nivram Management, Inc.	50.00%	21,324		21,324	6
7	V	5 Utilities		Nivram Management, Inc.	50.00%	2,131		2,131	7
8	V	26 Insurance		Nivram Management, Inc.	50.00%	1,218		1,218	8
9	V	6 Repairs & Maintenance		Nivram Management, Inc.	50.00%	1,508		1,508	9
10	V	22 Health Insurance		Nivram Management, Inc.	50.00%	8,106		8,106	10
11	V	6 Scavenger		Nivram Management, Inc.	50.00%	133		133	11
12	V	35 Rental Equipment		Nivram Management, Inc.	50.00%	429		429	12
13	V	2 Sales Taxes		Nivram Management, Inc.	50.00%	303		303	13
14	Total		\$			\$ 36,605	\$ *	36,605	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number

Winston Manor Cnv & Nursing

0035782

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	21 Postage	\$	Nivram Management, Inc.	50.00%	\$ 296	\$	296	15
16	V	19 Legal & Accounting		Nivram Management, Inc.	50.00%	548		548	16
17	V	20 Licenses & Permits		Nivram Management, Inc.	50.00%	121		121	17
18	V	25 Travel		Nivram Management, Inc.	50.00%	22		22	18
19	V	30 Depreciation		Nivram Management, Inc.	50.00%	1,008		1,008	19
20	V	21 Data Processing		Nivram Management, Inc.	50.00%	383		383	20
21	V	21 Telephone		Nivram Management, Inc.	50.00%	1,611		1,611	21
22	V	6 Plant Supervisor Salary		Nivram Management, Inc.	50.00%	29,021		29,021	22
23	V	17 Asst. Administrator		Nivram Management, Inc.	50.00%	43,531		43,531	23
24	V	21 Office Manager Salary		Nivram Management, Inc.	50.00%	35,172		35,172	24
25	V	1 Food Service Supervisor Salary		Nivram Management, Inc.	50.00%	28,000		28,000	25
26	V	17 Administrative Salaries		Nivram Management, Inc.	50.00%	90,852		90,852	26
27	V	17 Administrator Salary		Nivram Management, Inc.	50.00%	75,096		75,096	27
28	V	21 Clerical Salaries		Nivram Management, Inc.	50.00%	81,460		81,460	28
29	V	17 Management Fees	382,470	Nivram Management, Inc.	50.00%			(382,470)	29
30	V								30
31	V	43 Loss from Hamlin Investments		Pierce Building Partnership	50.00%	37,274		37,274	31
32	V	30 Depreciation		Pierce Building Partnership	50.00%	50,901		50,901	32
33	V	33 Real Estate Taxes		Pierce Building Partnership	50.00%	215,436		215,436	33
34	V	21 State Income Taxes		Pierce Building Partnership	50.00%	1,312		1,312	34
35	V	34 Rental Income	592,436	Pierce Building Partnership	50.00%			(592,436)	35
36	V								36
37	V								37
38	V								38
39	Total		\$ 974,906			\$ 692,044	\$ *	(282,862)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number

Winston Manor Cnv & Nursing

0035782

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Henry Mermelstein	Administrator	Administrative	0.00	517,277	5	13.10	Salary	\$ 77,978	17-7	1
2	Louise Mermelstein	Dietary Supervisor	Support	0.00	72,000	6	14.42	Salary	28,000	1-7	2
3	Marvin Mermelstein	Plant Supervisor	Support	75.70	76,979	4	20.71	Salary	29,021	6-7	3
4	Doreen Mermelstein	Office Manager	Support	0.00	79,388	17	43.45	Salary	35,172	21-7	4
5											5
6	Marvin Mermelstein	Asst. Administrator	Administrative	See Above	115,469	6	20.71	Salary	43,531	17-7	6
7	Joseph Mermelstein	Administrative	Administrative	24.30	43,436	2	20.71	Salary	12,874	17-7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 226,576		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Winston Manor Cnv & Nursing

0035782

Report Period Beginning:

01/01/2009

Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Nivram Management, Inc.
 Street Address 6500 N. Hamlin Avenue
 City / State / Zip Code Lincolnwood, IL 60712
 Phone Number (847) 679-7484
 Fax Number (847) 679-7494

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	21	Delivery Expense	Resident Beds	787	4	\$ 607	\$ 180	\$ 139	1	
2	21	Office Expenses	Resident Beds	787	4	4,945	180	1,131	2	
3	20	Dues & Subscriptions	Resident Beds	787	4	477	180	109	3	
4	21	Franchise Tax	Resident Beds	787	4	100	180	23	4	
5	32	Interest Expense	Resident Beds	787	4	221	180	51	5	
6	22	Payroll Taxes	Resident Beds	787	4	93,273	180	21,333	6	
7	5	Utilities	Resident Beds	787	4	9,320	180	2,132	7	
8	26	Insurance	Resident Beds	787	4	5,326	180	1,218	8	
9	6	Repair & Maintenance	Resident Beds	787	4	6,595	180	1,508	9	
10	22	Health Insurance	Resident Beds	787	4	35,458	180	8,110	10	
11	7	Scavenger	Resident Beds	787	4	580	180	133	11	
12	35	Renta Equipment	Resident Beds	787	4	1,876	180	429	12	
13	2	Sales Taxes	Resident Beds	787	4	1,324	180	303	13	
14	21	Postage	Resident Beds	787	4	1,295	180	296	14	
15	19	Legal & Accounting	Resident Beds	787	4	2,397	180	548	15	
16	20	Licenses & Permits	Resident Beds	787	4	530	180	121	16	
17	25	Travel	Resident Beds	787	4	95	180	22	17	
18	30	Depreciation	Resident Beds	787	4	4,409	180	1,008	18	
19	21	Data Processing	Resident Beds	787	4	1,675	180	383	19	
20	21	Telephone	Resident Beds	787	4	7,048	180	1,612	20	
21	6	Plant Supervisor Salary	Direct Cost	1	1	29,021	29,021	1	29,021	21
22	17	Asst. Administrator Salary	Direct Cost	1	1	43,531	43,531	1	43,531	22
23	21	Office Manager Salary	Direct Cost	1	1	35,172	35,172	1	35,172	23
24	1	Food Service Supervisor Salary	Direct Cost	1	1	28,000	28,000	1	28,000	24
25	TOTALS					\$ 313,275	\$ 135,724	\$ 176,333	25	

Facility Name & ID Number Winston Manor Cnv & Nursing

0035782

Report Period Beginning:

01/01/2009

Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Nivram Management, Inc.
 Street Address 6500 N. Hamlin Avenue
 City / State / Zip Code Lincolnwood, IL 60712
 Phone Number (847) 679-7484
 Fax Number (847) 679-7494

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	17	Administrative Salaries	Direct Cost	1	1	\$ 90,852	\$ 90,852	1	\$ 90,852	1
2	17	Administrator Salary	Direct Cost	1	1	75,096	75,096	1	75,096	2
3	21	Clerical Salaries	Direct Cost	1	1	81,460	81,460	1	81,460	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 247,408	\$ 247,408		\$ 247,408	25

Facility Name & ID Number

Winston Manor Cnv & Nursing

0035782

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1							\$	\$			\$	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6	Parkway Bank and Trust Co		X	Line of Credit	n/a	03/01/09	148,000		06/01/09	Prime	468	6						
7												7						
8												8						
9	TOTAL Facility Related						\$ 148,000	\$			\$ 468	9						
B. Non-Facility Related*																		
10	Interest Income										(468)	10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ (468)	14						
15	TOTALS (line 9+line14)						\$ 148,000	\$			\$	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill

1. Real Estate Tax accrual used on 2008 report.	\$	210,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	212,436	2
3. Under or (over) accrual (line 2 minus line 1).	\$	2,436	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	213,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	215,436	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2004	222,509	8
	2005	224,774	9
	2006	212,596	10
	2007	210,326	11
	2008	212,436	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2008	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Winston Manor Cnv & Nursing

0035782

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 59,192 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 4

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Nursing Home</u>		<u>1989</u>	<u>\$ 105,000</u>	1
2					2
3	TOTALS			\$ 105,000	3

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	180	1989		\$ 1,536,832	\$ 48,780	31.5	\$ 48,780	\$	\$ 981,968	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Security System	1990		9,200	292	31.5	292		5,804	9
10	Interior Improvements	1990		32,039	1,018	31.5	1,018		19,889	10
11	Elevator	1990		5,300	168	31.5	168		3,269	11
12	Tiling & Lobby Office	1990		10,143	321	31.5	321		6,212	12
13	Building Improvements	1991		3,230	103	31.5	103		1,904	13
14	Building Improvements	1991		4,806	153	31.5	153		2,817	14
15	Tiles	1991		11,906	377	31.5	377		6,818	15
16	Radiator Cover	1992		12,400	394	31.5	394		7,010	16
17	Electrical Work	1992		3,500	111	31.5	111		1,966	17
18	Building Improvements	1993		21,476	551	39	551		9,017	18
19	Building Improvements	1995		34,754	891	39	891		12,958	19
20	Flooring & Tile	1996		5,355	137	39	137		1,855	20
21	Generator	1996		35,589	912	39	912		12,363	21
22	Air Conditioner	1996		16,511	423	39	423		5,729	22
23	Alarm System	1996		3,744	96	39	96		1,300	23
24	Roof	1996		1,200	31	39	31		420	24
25	Hot Water Heater	1996		2,900	74	39	74		1,002	25
26	Smoke Eater	1993		4,600		10			4,600	26
27	Air Conditioner	1993		2,550		10			2,550	27
28	Carpet	1993		3,527		10			3,527	28
29	Boiler	1993		3,600		10			3,600	29
30	Air Conditioner	1994		5,122		10			5,122	30
31	Hot Water Heater	1995		4,160		10			4,160	31
32	Air Conditioner	1995		2,816		10			2,816	32
33	Glass	1995		647		10			647	33
34	Roof	1997		21,350	548	39	548		7,048	34
35	Phone System	1997		13,666	350	39	350		4,481	35
36										36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Winston Manor Cnv & Nursing

0035782

Report Period Beginning:

01/01/2009 Ending: 12/31/2009

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Electrical Work	1997	\$ 49,685	\$ 1,274	39	\$ 1,274	\$	\$ 16,085	37
38	Central Air Conditioning	1997	35,499	910	39	910		11,492	38
39	New Office Construction	1997	4,442	114	39	114		1,438	39
40	Boiler Insulation	1997	29,412	754	39	754		9,521	40
41	Fire Alarm & Sprinkler	1997	2,475	64	39	64		800	41
42	Doors & Construction	1997	8,190	210	39	210		2,581	42
43	Plumbing - Toilets & Pipes	1997	4,719	121	39	121		1,497	43
44	Roof	1998	3,900	100	39	100		1,188	44
45	HVAC Work	1998	2,700	69	39	69		816	45
46	Doors & Construction	1998	2,729	70	39	70		785	46
47	Time Clock	1998	5,245	135	39	135		1,551	47
48	Air Conditioner	1998	777	20	39	20		230	48
49	Phone System	1998	1,283	33	39	33		385	49
50	Door	1999	2,500	64	39	64		654	50
51	Fire Damper	1999	1,783	46	39	46		471	51
52	Water System	1999	6,000	154	39	154		1,558	52
53	Door Construction	1999	2,500	64	39	64		654	53
54	Kitchen and Tiling	1999	10,250	263	39	263		2,837	54
55	New Windows	2001	1,300	33	39	33		265	55
56	Doors & Frame	2001	2,025	53	39	53		423	56
57	Electric Wiring	2001	443	11	39	11		89	57
58	Wall Repair	2001	1,000	26	39	26		208	58
59	Roof Repair	2003	1,150	15	39	15		669	59
60	Brick Paver	2004	40,000	1,025	39	1,025		5,299	60
61	Tuckpointing	2004	23,518	603	39	603		3,266	61
62	Building Improvement from Building Partnership	1995	74,705	2,121	39	2,121		35,353	62
63	Bathroom Remodeling	2005	5,125	131	39	131		558	63
64	Pump	2005	2,600	67	39	67		306	64
65	Water Heater	2005	7,400	190	39	190		775	65
66	Elevator Machine Room	2006	41,767	1,071	39	1,071		3,213	66
67	Boiler Insulation	2006	32,500	833	39	833		2,639	67
68	Symmetry Construction	2006	5,500	141	39	141		458	68
69	Kitchen Fire Safety System	2006	1,600	42	39	42		127	69
70	TOTAL (lines 4 thru 69)		\$ 2,227,645	\$ 66,557		\$ 66,557	\$	\$ 1,229,043	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,227,645	\$ 66,557		\$ 66,557	\$	\$ 1,229,043	1
2	Elevator Recall System	2006	4,500	115	39	115		346	2
3	Wireless Temperature Control	2006	3,500	90	39	90		277	3
4	Pushbutton Lock	2006	380	10	39	10		30	4
5	Roof	2006	7,100	182	39	182		546	5
6	Boiler	2007	26,890	689	39	689		1,896	6
7	Elevator Equipment	2007	8,171	210	39	210		524	7
8	Power Flame Gas Burner	2007	7,000	179	39	179		381	8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,285,186	\$ 68,032		\$ 68,032	\$	\$ 1,233,043	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 12,944	\$ 2,328	\$ 2,589	\$ 261	5-7	\$ 11,974	71
72	Current Year Purchases	4,300	1,147	860	(287)	5	860	72
73	Fully Depreciated Assets	510,078				5-7	510,078	73
74	Management Company		1,008	1,662	654	5-7		74
75	TOTALS	\$ 527,322	\$ 4,483	\$ 5,111	\$ 628		\$ 522,912	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	2001 Ford Taurus	2006	\$ 2,245	\$ 259	\$ 431	\$ 172	5	\$ 992	76
77										77
78										78
79										79
80	TOTALS			\$ 2,245	\$ 259	\$ 431	\$ 172		\$ 992	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,919,753	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 72,774	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 73,574	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 800	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,756,947	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34. _____

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: Annual Lease *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

YES NO

16. Rental Amount for movable equipment: \$ 3,005 Description: Ice Maker - \$900; Copier - \$2,126; Copier - Mng Company - \$429

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18	<u>See Attached Schedule</u>			<u>22,185</u>	18
19					19
20					20
21	TOTAL		\$	\$ 22,185	21

10. Effective dates of current rental agreement:

Beginning 01/01/2009

Ending 12/31/2009

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2010 \$ _____

13. /2011 \$ _____

14. /2012 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$			\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): <u>Respiratory</u>	<u>39-2</u>					<u>350</u>		<u>350</u>	13
14	TOTAL			\$		\$	<u>350</u>		\$ <u>350</u>	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Winston Manor Cnv & Nursing# 0035782Report Period Beginning: 01/01/2009Ending: 12/31/2009

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2009

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 631,835	\$ 631,972	1
2	Cash-Patient Deposits	14,098	14,098	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	618,973	618,973	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	53,865	53,865	6
7	Other Prepaid Expenses	5,912	5,912	7
8	Accounts Receivable (owners or related parties)	10,671	7,531	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,335,354	\$ 1,332,351	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		105,000	13
14	Buildings, at Historical Cost		1,536,832	14
15	Leasehold Improvements, at Historical Cost	646,655	721,360	15
16	Equipment, at Historical Cost	556,560	556,560	16
17	Accumulated Depreciation (book methods)	(732,045)	(1,749,366)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe Deposits	500	500	22
23	Other(specify): <u>Investment in Partnership</u>		518,459	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 471,670	\$ 1,689,345	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,807,024	\$ 3,021,696	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 57,781	\$ 57,781	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	14,848	14,848	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	20,301	20,301	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		213,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	28,369	29,681	35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	3,287,267	3,287,267	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,408,566	\$ 3,622,878	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,408,566	\$ 3,622,878	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,601,542)	\$ (601,182)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,807,024	\$ 3,021,696	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (900,300)	1
2	Restatements (describe):		2
3	Rounding	2	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (900,298)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,108,175	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(1,809,419)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (701,244)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,601,542)	24 *

* This must agree with page 17, line 47.

**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,408,839	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,408,839	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	871	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 871	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	45,970	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 45,970	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Vending Income</u>	4,375	28
28a	<u>Miscellaneous Income</u>	13,307	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 17,682	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,473,362	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	897,837	31
32	Health Care	1,660,892	32
33	General Administration	1,040,053	33
	B. Capital Expense		
34	Ownership	638,530	34
	C. Ancillary Expense		
35	Special Cost Centers	350	35
36	Provider Participation Fee	98,550	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,336,212	40
41	Income before Income Taxes (line 30 minus line 40)**	1,137,150	41
42	Income Taxes	(28,975)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,108,175	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Winston Manor Cnv & Nursing

0035782

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,776	1,992	\$ 69,954	\$ 35.12	1
2	Assistant Director of Nursing	1,840	1,968	55,168	28.03	2
3	Registered Nurses	15,845	16,810	330,255	19.65	3
4	Licensed Practical Nurses	2,121	2,339	44,867	19.18	4
5	CNAs & Orderlies	49,358	53,818	597,392	11.10	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,983	2,239	32,390	14.47	8
9	Activity Director	1,890	2,133	23,891	11.20	9
10	Activity Assistants	6,529	6,921	63,511	9.18	10
11	Social Service Workers	11,599	12,312	154,466	12.55	11
12	Dietician					12
13	Food Service Supervisor	2,045	2,261	40,423	17.88	13
14	Head Cook					14
15	Cook Helpers/Assistants	18,084	19,644	192,470	9.80	15
16	Dishwashers					16
17	Maintenance Workers	4,225	4,573	65,918	14.41	17
18	Housekeepers	19,083	20,319	192,366	9.47	18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator	1,240	1,280	28,300	22.11	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,720	4,894	41,872	8.56	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,159	2,207	20,896	9.47	31
32	Other Health Care(specify)					32
33	Other(specify) <u>MDS Coordinator</u>	2,064	2,280	54,264	23.80	33
34	TOTAL (lines 1 - 33)	146,561	157,990	\$ 2,008,403 *	\$ 12.71	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	M	\$ 9,795	1-3	35
36	Medical Director	O	3,250	9-3	36
37	Medical Records Consultant	N	1,820	10-3	37
38	Nurse Consultant	T			38
39	Pharmacist Consultant	H			39
40	Physical Therapy Consultant	L			40
41	Occupational Therapy Consultant	Y	195	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	F			43
44	Activity Consultant	E			44
45	Social Service Consultant	E	8,115	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 23,175		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	7,124	\$ 168,444	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	7,124	\$ 168,444		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
<u>Annett Betancur</u>	<u>Asst Administ</u>	<u>0</u>	\$ <u>28,300</u>	<u>Workers' Compensation Insurance</u>	\$ <u>45,523</u>	<u>IDPH License Fee</u>	\$ <u>883</u>	
				<u>Unemployment Compensation Insurance</u>	<u>20,683</u>	<u>Advertising: Employee Recruitment</u>	<u>883</u>	
				<u>FICA Taxes</u>	<u>152,593</u>	<u>Health Care Worker Background Check</u>	<u>201</u>	
				<u>Employee Health Insurance</u>	<u>109,592</u>	(Indicate # of checks performed <u>27</u>)	<u>201</u>	
				<u>Employee Meals</u>	<u>18,828</u>	<u>Patient Background Checks</u>	<u>460</u>	
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Yellow Pages Advertising</u>	<u>6,098</u>	
				<u>Chicago Head Tax</u>	<u>2,772</u>	<u>See Attached Schedule</u>	<u>16,022</u>	
				<u>Union Pension</u>	<u>20,522</u>	<u>Allocation from Management Company</u>	<u>230</u>	
				<u>Allocation from Management Company</u>	<u>29,430</u>			
TOTAL (agree to Schedule V, line 17, col. 1)			\$ <u>28,300</u>					
(List each licensed administrator separately.)								
B. Administrative - Other								
Description			Amount					
<u>Management Fees</u>			<u>\$ 382,470</u>					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ <u>382,470</u>					
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Description	Amount	
<u>Kessler, Orlean, Silver</u>	<u>Accounting</u>		<u>\$ 17,550</u>			<u>Out-of-State Travel</u>	\$ <u> </u>	
<u>E Health Data Solutions</u>	<u>Medicare/Medicade Consltn</u>		<u>6,554</u>					
<u>Accu-Med Services</u>	<u>Computer</u>		<u>2,640</u>					
<u>Health Data Systems</u>	<u>Computer</u>		<u>1,890</u>			<u>In-State Travel</u>		
<u>Automatic Data Processing</u>	<u>Payroll Service</u>		<u>2,745</u>					
<u>Medifax-EDI, LLC</u>	<u>Computer</u>		<u>664</u>					
<u>IL Assoc of Health Care Facilities</u>	<u>Union Negotiations</u>		<u>2,160</u>					
<u>Inovative LTC Solutions</u>	<u>Billing Service</u>		<u>9,182</u>			<u>Seminar Expense</u>	<u>1,480</u>	
<u>Personnel Planner</u>	<u>U/C Consultant</u>		<u>2,104</u>					
<u>Commitment Consulting</u>	<u>Billing Service</u>		<u>1,263</u>					
<u>See Attached Schedule</u>	<u>Legal</u>		<u>4,831</u>			<u>Entertainment Expense</u>	(<u> </u>)	
TOTAL (agree to Schedule V, line 19, column 3)			\$ <u>51,583</u>	TOTAL			\$ <u>1,480</u>	
(If total legal fees exceed \$5,000, attach copy of invoices.)								

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Winston Manor Cnv & Nursing# 0035782Report Period Beginning: 01/01/2009Ending: 12/31/2009**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IL Council on Long Term Care \$13,851
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5-7 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line N/A
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES No NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 98,550
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? Yes If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 18,828 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees